DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th day 6/30/12

PRINTED: 06/04/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445114	A. BUILDING _____ B. WING _____	C 05/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRAKEBILL NURSING HOME INC.	5837 LYONS VIEW PIKE KNOXVILLE, TN 37919

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to follow physician's orders by obtaining and recording blood pressures prior to administration of antihypertensive medications for one resident (#1) of five residents reviewed. The findings included: Resident #1 was admitted to the facility on December 8, 2011, with diagnoses including Atrial Fibrillation (irregular heart beat), Senile Dementia, and Chronic Pain. Medical record review of the Minimum Data Set (MDS) dated March 12, 2012, revealed the resident was cognitively intact, with a score of 15 out of 15 on the Brief Interview for Mental Status (BIMS). Medical record review of a Physician's Order dated December 8, 2011, revealed "...Enalapril (blood pressure medication) 20mg (milligrams) PO (by mouth) QD (every day) HOLD for SBP (systolic blood pressure) < (less than) 110..." Medical record review of the Medication Administration Record (MAR) for the month of May 2012 revealed no blood pressures (BP) had been documented prior to the administration of an antihypertensive medication (Enalapril). No	F 281	What corrective action will be accomplished for those residents found to have been affected by the deficient practice: The blood pressures and medication order of resident #1 was evaluated by the physician when medication error was discovered on 5/29/12. The medication was rewritten by the physician and discontinued. Blood pressure readings were ordered 8 shift times 3 days. Blood pressure was documented stable by the M.D. Resident #1 experienced no negative outcome. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents ~~having the~~ error NF on anti-hypertensive drugs that have blood pressure parameters	6-7-12 6-7-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Norma E Linosa RN
TITLE: Administrator
(X6) DATE: 6-7-12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

JUN 07 2012

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F 281	Continued From page 1 BPs were obtained/documented May 1, 2012, through May 12, 2012, for the 8:00 a.m. doses nor the 4:00 p.m. doses, with the exception of two documented BPs for the 4:00 p.m. doses on May 4 and May 5, 2012. Interview with Licensed Practical Nurse (LPN #1), on May 31, 2012, at 7:35 a.m., at the 400 hall Nurses Station, confirmed the medication nurses obtain the vital signs associated with medication administration. Continued interview with LPN #1, confirmed the BP parameters had been prescribed by the physician but not obtained/documented prior to administering the antihypertensive as detailed above. Interview with the Director of Nurses and the Administrator on May 31, 2012, at 8:10 a.m., in the staff education room, confirmed the physician's order did include blood pressure parameters for safe administration of the medication and the facility had failed to follow the physician's order twenty-two times by not obtaining BPs prior to the administration of an antihypertensive medication from May 1, 2012 through May 12, 2012.	F 281	ordered before giving have the potential to be affected. The DON conducted an audit on current Medication Administration Records on 6-6-12 to identify blood pressures not documented as ordered before blood pressure medications are given. Any discrepancies identified will be reported to physician immediately and the nurse caring for the resident will be counseled regarding any omission of blood pressure documentation. What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur. Licensed and Registered nurses who give meds will be inserviced by the DON or designee on proper documentation	6-7-12
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.	~~F 329~~		

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F 329	Continued From page 2 Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to follow physician's medication orders resulting in twenty-seven unnecessary medication doses for one resident (#1) of five residents reviewed. The findings included: Resident #1 was admitted to the facility on December 8, 2011, with diagnoses including Atrial Fibrillation (irregular heart beat), Senile Dementia, and Chronic Pain. Medical record review of the Minimum Data Set (MDS) dated March 12, 2012, revealed the resident was cognitively intact, with a score of 15 out of 15 on the Brief Interview for Mental Status (BIMS).	~~F 329~~	of blood pressures when ordered by the physician before giving medications and the importance of compliance with all medication instructions on the MAR. The unit secretaries will be instructed to underline in red on the MAR any order that requires a blood pressure to be obtained before giving medication to alert nurse. When new MAR's are printed each month, the nurses reviewing orders will be instructed on underlining in red orders that require a B/P check. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; ie, what quality assurance program will be put into place. Audits consisting of 20% of MAR'S will be conducted by the DON or designee weekly times 4 then monthly times 3. All audit findings will be reported to QA for further need of monitoring.	6-7-12

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F 329	Continued From page 3 Medical record review of a Physician's Order dated December 8, 2011, revealed "...Enalapril (blood pressure medication) 20mg (milligrams) PO (by mouth) QD (every day) HOLD for SBP (systolic blood pressure) < (less than) 110..." Medical record review of the May 2012 recapitulation orders revealed "...Enalapril 20mg PO QD HOLD for SBP < 110..." Medical record review of the Medication Administration Record (MAR) for the months of March 2012 and April 2012 revealed the medication had been properly administered (once daily) each day of March 2012 and April 2012. Medical record review of the Medication Administration Record (MAR) for the month of May 2012 revealed Enalapril 20 mg had been administered to the resident twice a day (not once a day as ordered), at 8:00 a.m. and again at 4:00 p.m., May 1, 2012 through May 27, 2012, when the error was identified. This resulted in twenty-seven unnecessary doses of the blood pressure medication. Interview with the Director of Nurses (DON) and the Administrator on May 31, 2012, at 8:10 a.m., in the staff education room confirmed the physician's order had not been transcribed correctly at the beginning of the month (May 2012), resulting in twenty-seven unnecessary medication doses. Continued interview with the DON and the Administrator confirmed the medication error had not been previously reported and no investigation of the medication error had been completed.	F 329	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #1 which was given extra doses of Enalapril in May because of being transcribed incorrectly on the MAR, this was immediately corrected when noticed and the physician was notified. All new orders given by physician were completed immediately. Blood pressure was monitored and remained stable. 6-7-12 How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by the deficient practice. All nursing staff will be instructed on reading their medication labels which state the times medications are to be given and if it states something different	6-7-12

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		F 329	than what the MAR states orders must be verified in the chart. What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur: All nursing staff will be inserviced by the DON or designee beginning 6/6/12 on the importance of reading medication label instructions and comparing them to the order on the MAR and when there is a discrepancy verification must be done by chart review. If any discrepancies are noticed an incident report must be filled out and physician notified DON or Administrator must be notified of incident report to ensure investigation is completed.	6-7-12 6-7-12

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		F 329	How the corrective action(s) will be monitored to ensure the deficient practice will not recur: All med incident reports will be reported to the QA committee monthly times 4, then quarterly.	6-7-12

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